COMMENTARY

Patient grievances are a continuing challenge for medical science

"I want to believe that my physician is acting under higher moral principles and intellectual powers than a used-car dealer."[1]

This comment of a physician-patient nearing the end of an illustrious career summarizes a capitalist society's special expectations of physicians. Twenty years ago, those expectations were easier to meet. Today's physicians operate increasingly where ethics conflict with profits: less time to talk, research, and think and fewer incentives to care as well as cure. Diminished patient comfort, at least in the view of some, is acceptable as long as "outcomes" are not compromised. Halperin summarizes his 11 years of experience with a medical society's grievance committee in a well-known center of clinical practice in the country during this time of undiminished patient expectations and rapid change in the organization of medical care.

Denominators are often forgotten in the discussion of physician errors, malpractice suits, and aggrieved patients. Numerators—the bigger the better—make the news. Assuming that the 2,394 physicians practicing in Durham and Orange counties each experienced 2,000 patient encounters per year (10 per day) over these 11 years, there would be 53 million opportunities for patient discontent with care. Twenty-nine reported grievances produce a rate of 0.6 per 1,000,000. Overall, this record translates into a remarkable decade of amicable human interaction.

Low rates should not lead us to dismiss the problem of patient dissatisfaction. Just as we demonstrate great concern over airplane crashes, however infrequent, there is much to be said for zero tolerance for avoidable patient injury or fractured patient-physician relationships. Of more relevance, while we can count air mishaps or auto accidents easily, we cannot do the same for patient grievances. As Halperin reports, only a small fraction of patients injured as a result of medical negligence file a malpractice claim. In all likelihood, most patients go home angry but adjust and forget with time. Despite many attempts to collect and report data on adverse patient encounters, our knowledge of the scope and nature of the problem is limited by poor definitions and inadequate methods for data collection. Litigation might help to compensate some patients, but it thoroughly frustrates attempts to assess and study physician-patient disaffection. Even the National Practitioner Data Bank, the federal repository of disciplinary and malpractice actions against physicians, surely underreports patients' malpractice suits against their physicians.

Several recent reports have examined efforts to measure and improve relationships. Kraman and Hamm examined the Department of Veterans Affairs medical system's policy of full disclosure of medical mistakes to patients and their families, a policy implemented to maintain the physician's role as caregiver and advocate.[2] Such a radical departure from a posture of defense (or denial) must be accompanied by complete reporting and open discussion.[3] Hickson and colleagues document what we have long known: a physician's poor interpersonal skills can precipitate suits.[4] Their current research focuses on methods of identifying and counseling physicians at risk. Effective interventions are neither easy nor a priori worthwhile. A randomized controlled trial of a managed care continuing medical education program entitled "Thriving in a Busy Practice: Physician-Patient Communication" failed to demonstrate improved patient satisfaction in the intervention over the control group.[5] Reducing or settling grievances remains yet another in the long list of biomedical challenges that will not be solved with the mapping of the human genome.

Managed care, patients' rights, and patient access to care are political issues closely related to patient satisfaction. Halperin's report gives us yet another window on the nature of grievances. But reports about grievances are still too few. If every entity were able to collect and combine for analysis their data on such grievances, we might then begin to understand fully the nature of these disputes and, of more importance, to assess intelligently the effects of new laws and health care organizations on physician-patient relationships.

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